HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 2323 By: Frix

COMMITTEE SUBSTITUTE

An Act relating to insurance; amending 36 O.S. 2011, Section 6055, which relates to health insurance; prohibiting certain health insurers from removing provider from a network for certain reasons; providing prohibition shall not apply to certain contract expirations; prohibiting restrictions on out-of-network referrals; requiring certain signed acknowledgement; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 36 O.S. 2011, Section 6055, is amended to read as follows:

Section 6055. A. Under any accident and health insurance policy, hereafter renewed or issued for delivery from out of Oklahoma or in Oklahoma by any insurer and covering an Oklahoma risk, the services and procedures may be performed by any practitioner selected by the insured, or the parent or guardian of the insured if the insured is a minor, if the services and

procedures fall within the licensed scope of practice of the practitioner providing the same.

B. An accident and health insurance policy may:

1. Exclude or limit coverage for a particular illness, disease, injury or condition; but, except for such exclusions or limits, shall not exclude or limit particular services or procedures that can be provided for the diagnosis and treatment of a covered illness, disease, injury or condition, if such exclusion or limitation has the effect of discriminating against a particular class of practitioner. However, such services and procedures, in order to be a covered medical expense, must:

a. be medically necessary,

b. be of proven efficacy, and

c. fall within the licensed scope of practice of the practitioner providing same; and

2. Provide for the application of deductibles and copayment provisions, when equally applied to all covered charges for services and procedures that can be provided by any practitioner for the diagnosis and treatment of a covered illness, disease, injury or condition.

C. 1. Paragraph 2 of subsection B of this section shall not be construed to prohibit differences in cost-sharing provisions such as deductibles and copayment provisions between practitioners, hospitals and ambulatory surgical centers who are participating

preferred provider organization providers and practitioners, hospitals and ambulatory surgical centers who are not participating in the preferred provider organization, subject to the following limitations:

a. the amount of any annual deductible per covered person or per family for treatment in a hospital or ambulatory surgical center that is not a preferred provider shall not exceed three times the amount of a corresponding annual deductible for treatment in a hospital or ambulatory surgical center that is a preferred provider,

b. if the policy has no deductible for treatment in a preferred provider hospital or ambulatory surgical center, the deductible for treatment in a hospital or ambulatory surgical center that is not a preferred provider shall not exceed One Thousand Dollars ($1,000.00) per covered-person visit,

c. the amount of any annual deductible per covered person or per family treatment, other than inpatient treatment, by a practitioner that is not a preferred practitioner shall not exceed three times the amount of a corresponding annual deductible for treatment, other than inpatient treatment, by a preferred practitioner,

d. if the policy has no deductible for treatment by a preferred practitioner, the annual deductible for treatment received from a practitioner that is not a preferred practitioner shall not exceed Five Hundred Dollars ($500.00) per covered person,

e. the percentage amount of any coinsurance to be paid by an insured to a practitioner, hospital or ambulatory surgical center that is not a preferred provider shall not exceed by more than thirty (30) percentage points the percentage amount of any coinsurance payment to be paid to a preferred provider.

2. The Commissioner has discretion to approve a cost-sharing arrangement which does not satisfy the limitations imposed by this subsection if the Commissioner finds that such cost-sharing arrangement will provide a reduction in premium costs.

D. 1. A practitioner, hospital or ambulatory surgical center that is not a preferred provider shall disclose to the insured, in writing, that the insured may be responsible for:

a. higher coinsurance and deductibles, and

b. practitioner, hospital or ambulatory surgical center charges which exceed the allowable charges of a preferred provider.

2. When a referral is made to a nonparticipating hospital or ambulatory surgical center, the referring practitioner must disclose

in writing to the insured, any ownership interest in the nonparticipating hospital or ambulatory surgical center.

E. Upon submission of a claim by a practitioner, hospital, home care agency, or ambulatory surgical center to an insurer on a uniform health care claim form adopted by the Insurance Commissioner pursuant to Section 6581 of this title, the insurer shall provide a timely explanation of benefits to the practitioner, hospital, home care agency, or ambulatory surgical center regardless of the network participation status of such person or entity.

F. Benefits available under an accident and health insurance policy, at the option of the insured, shall be assignable to a practitioner, hospital, home care agency or ambulatory surgical center who has provided services and procedures which are covered under the policy. A practitioner, hospital, home care agency or ambulatory surgical center shall be compensated directly by an insurer for services and procedures which have been provided when the following conditions are met:

1. Benefits available under a policy have been assigned in writing by an insured to the practitioner, hospital, home care agency or ambulatory surgical center;

2. A copy of the assignment has been provided by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer;

3. A claim has been submitted by the practitioner, hospital, home care agency or ambulatory surgical center to the insurer on a uniform health insurance claim form adopted by the Insurance Commissioner pursuant to Section 6581 of this title; and

4. A copy of the claim has been provided by the practitioner, hospital, home care agency or ambulatory surgical center to the insured.

G. The provisions of subsection F of this section shall not apply to:

1. Any preferred provider organization (PPO) as defined by generally accepted industry standards, that contracts with practitioners that agree to accept the reimbursement available under the PPO agreement as payment in full and agree not to balance bill the insured; or

2. Any statewide provider network which:

a. provides that a practitioner, hospital, home care agency or ambulatory surgical center who joins the provider network shall be compensated directly by the insurer,

b. does not have any terms or conditions which have the effect of discriminating against a particular class of practitioner,

c. allows any practitioner, hospital, home care agency or ambulatory surgical center, except a practitioner who

has a prior felony conviction, to become a network provider if said hospital or practitioner is willing to comply with the terms and conditions of a standard network provider contract, and

d. contracts with practitioners that agree to accept the reimbursement available under the network agreement as payment in full and agree not to balance bill the insured.

H. A nonparticipating practitioner, hospital or ambulatory surgical center may request from an insurer and the insurer shall supply a good-faith estimate of the allowable fee for a procedure to be performed upon an insured based upon information regarding the anticipated medical needs of the insured provided to the insurer by the nonparticipating practitioner.

I. A practitioner shall be equally compensated for covered services and procedures provided to an insured on the basis of charges prevailing in the same geographical area or in similar sized communities for similar services and procedures provided to similarly ill or injured persons regardless of the branch of the healing arts to which the practitioner may belong, if:

1. The practitioner does not authorize or permit false and fraudulent advertising regarding the services and procedures provided by the practitioner; and

2. The practitioner does not aid or abet the insured to violate the terms of the policy.

J. Nothing in the Health Care Freedom of Choice Act shall prohibit an insurer from establishing a preferred provider organization and a standard participating provider contract therefor, specifying the terms and conditions, including, but not limited to, provider qualifications, and alternative levels or methods of payment that must be met by a practitioner selected by the insurer as a participating preferred provider organization provider.

K. A preferred provider organization, in executing a contract, shall not, by the terms and conditions of the contract or internal protocol, discriminate within its network of practitioners with respect to participation and reimbursement as it relates to any practitioner who is acting within the scope of the practitioner's license under the law solely on the basis of such license.

L. Decisions by an insurer or a preferred provider organization (PPO) to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;

2. Impairment of bodily function; or

3. Dysfunction of any bodily organ or part.

M. An insurer or preferred provider organization (PPO) shall not deny an otherwise covered emergency service based solely upon lack of notification to the insurer or PPO.

N. An insurer or a preferred provider organization (PPO) shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the policy or PPO contract.

O. Nothing in this act shall be construed as prohibiting an insurer, preferred provider organization or other network from determining the adequacy of the size of its network.

P. An insurer or a preferred provider organization shall not unilaterally remove a provider from the network, solely because the provider informs an enrollee of the full range of physicians and providers available to the enrollee, including out-of-network providers. Nothing in this Act prohibits any insurer from allowing a contract to expire by its own terms or negotiating a new contract with the provider at the end of the contract term. A provider agreement shall not, as a condition of the agreement, prohibit,

penalize, terminate, or otherwise restrict a preferred provider from referring to an out-of-network provider, provided the insured signs an acknowledgment of referral that the insured may be responsible for:

1. higher coinsurance and deductibles, and

2. charges which exceed the allowable charges of a preferred provider.

SECTION 2. This act shall become effective November 1, 2021.

COMMITTEE REPORT BY: COMMITTEE ON INSURANCE, dated 02/24/2021 - DO PASS, As Amended.